HEALTH CARE SPENDING ACCOUNT
Claim for Reimbursement

NAME OF EMPLOYER		
EMPLOYEE NAME	**SOCIAL SECURITY NUMBER**	
EMPLOYEE ADDRESS	**STREET**	**CITY**
STATE	**ZIP**	**PHONE NO:**

HEALTH CARE EXPENSES

PATIENT NAME	DATES OF SERVICE FROM	TO	PROVIDER OF SERVICE	(A) TOTAL CHARGE	(B) AMOUNT PAID BY OTHER SOURCES	(A-B) AMOUNT TO BE REIMBURSED
					TOTALS	

CERTIFICATION

I certify that the expenses for which I am requesting reimbursement meet all of the conditions listed below:
- They were incurred for services or supplies received by me or my eligible dependents under the plan.
- They were for services or supplies furnished while I was a participant in the Plan.
- I have not been reimbursed for these expenses, and they are not reimbursable from any other health plan.

I understand that reimbursement of these expenses can be requested and made only after I have collected all benefit payments available from all plans under which my eligible dependents and I are covered. I further certify that I have not deducted nor will deduct on my individual income tax return any of the expenses reimbursed through my Health Care Spending Account.
I understand that reimbursement will be made in accordance with the provisions of the plan which I participate. I accept responsibility for the proper treatment of benefits paid under this plan with respect to eligibility, income tax reporting, and liability.

COMPLETION OF CLAIM FORM

- Complete all information on the claim form for each amount claimed for reimbursement.
- Make sure the claim does not include items for more than **one plan year**.
- You **must** sign and date claim form.
- A copy of a bill or other written statement from the provider of service **is acceptable only when NO other insurance is applicable.**
- **Cancelled Checks/Credit Card Statements are NOT acceptable.**
- If insurance is applicable, a statement/explanation of benefits from **ALL MEDICAL/DENTAL INSURANCE CARRIERS SHOWING DEDUCTIBLE, COPAYMENTS AND PAYMENTS IS REQUIRED.**

EMPLOYEE SIGNATURE_____**DATE**_____

MAIL COMPLETED FORM TO:

FBA OF SYOSSET, LLC
100 QUENTIN ROOSEVELT BLVD, SUITE 403
GARDEN CITY, NY 11530
PHONE (855) 374-6431 FAX (833) 930-1024
WWW.FBANATIONAL.COM
Claims@fbaofsyosset.com